STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING:		
		DD0239	B. WING		C 07/18/2014
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
SECOND F	FAMILY, INC		SHTSEAT ROAD SI ER, MD 20785	UITE 111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
L 000	response to an agent indicating neglect. The residential site DL673 included the review of the incident, program Individual 8268, review as observation of the and observations of staff. Based upon the neglect was substant found to be in complicated by the substant of the substant found to be in complicated and COMAR 14.31.0 Program Regulations	OOZ11, was initiated in cy Incident Reporting Form the Individual was at the control of the cont	L 000		
L 375	10.27.11 .10 Policies and Proc A. A licensee shall d policies and procedur (9) Compliance with This Regulation is not [Site # DL6734 Ser A review of records ro Nursing Assessment	evelop and adopt written res for ensuring:	L 375		

OHCO
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A, BUILDING:		COMPLETED	
					С	
DD0239		B. WING		07/18/2014		
					0771072014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
SECOND	FAMILY, INC		HTSEAT ROAD S	UITE 111		
		LANDOVE	R, MD 20785			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
L 375	Continued From page 1		L 375			
L1140	Supervision. C. For the client whose criteria as stated in R chapter the registered shall make a supervisive residence at a minimum (5) Evaluate the envir delegated task is perfusive fineglic	d nurse managing the case sory visit to the client's um of every 45 days to: ronment in which the	L1140			
	of the IP. B. Individual rights, w (3) Being free from all mistreatment;	which include: buse, neglect, and				
	[Site # DL6734 Ser Investigation revealer having am hygiene co. #1 was alone at the bild down. Staff #1 walke several times with the position. Individual 80 onto the floor as Staff bed. Staff #1 attempt but was unsuccessful to be bleeding from the was given by nursing transferred to the hose	ot met as evidenced by: vice[GH Individual # 8268] Individual 8268 was are given by Staff # 1. Staff bedside with the bed siderails of away from the bedside as side rails in the down 268 rolled out of the bed and of #1 was at the foot of the ded to catch Individual 8268 I. Individual 8268 was noted the mouth area and first aid of staff. Individual 8268 was spital via ambulance. Iterated and diagnosed with a				

онсо

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT A, BUILDING: COM	
			K, BOILDING.		С
DD0239		B. WING		07/18/2014	
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA	adinara nyaét	
SECOND I	AMILY, INC		HTSEAT ROAD R, MD 20785	SUITE 111	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
L1140	Continued From page	2	L1140	1	10.74
Y2335	had a history of movir bed. The Nursing Car 11-23-2011, states the rails up at all times wh the bed rails should be with padding as need Individual 8268's envi- bed. The House Coordinat interview on July18, 2 8:30am, that two staff Individual 8268's hygi	014 at approximately are to be present during	Y2335		
	n Annual .05 Personnel Admini F. Training of Child Ca (1) Each employee with children shall receive initial and annual train This Regulation is not [Site # DL6734 Senter DL6734 Senter Sent	stration. are Workers. no provides direct care to a minimum of 40 hours of hing. at met as evidenced by: vice GH Individual # 8268 dinterview with the Director			

онсо

YBF511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000		(X3) DATE SURVEY COMPLETED		
		100000000000000000000000000000000000000	A. BUILDING:		COMPLETED		
DD0239		B. WING		C 07/18/2014			
NAME OF PE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SECOND I	AMILY, INC		ITSEAT ROAD R, MD 20785	SUITE 111			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
Y2520	14,31,06,06B1a Emp Duties: Dir Care: Help Kids w/ Goals		Y2520				
	.06 Employee Duties	and Qualifications.					
	B. Direct Care Staff.						
	(1) The licensee shall employ direct child care staff to:						
	(a) Assist the children objectives of their ind	n in meeting the goals and ividual service plans;					
Y2535	[Site # DL6734 Senterview 7-18-14 at approximates responded no when a was familiar with Indix A review of records distaff #2 had been traindividual Plan. 14.31.06.06B1d Emp Kids Beh .06 Employee Duties B. Direct Care Staff.	l employ direct child care	Y2535				

OHCQ STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
DD0239		B. WING	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STATE	E. ZIP CODE	07/18/2014		
SECOND	SECOND FAMILY, INC 337 BRIGHTSEAT ROAD SUITE 111 LANDOVER, MD 20785						
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
Y2535	Continued From page	2.4	Y2535				
Y4180	[Site # DL6734 Sen Staff #2 was interview 7-18-14 at approxima responded no when a was familiar with Indiv Plan, A review of reco that Staff #2 had been Behavioral Plan.	ot met as evidenced by: vice GH Individual # 8268 ved during the site visit on tely 7:15am. Staff #2 ssked if he had reviewed or vidual 8268's Behavioral ords did not reveal evidence in trained in Individual 8268's care: Med Care: Writ P n P 4	Y4180				
	.13 Health Care. D. Medical Care. The (5) Have and follow w procedures for the proservices.	ritten policies and					
нсо							

STATE FORM

(42)